Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RICHARD B. LAWRENCE, MD
PO BOX 741865
DALLAS, TX 75374

Respondent Name
LION INSURANCE CO

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-2967-01

MFDR Date Received
MAY 23, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier is required to pay designated doctor exams...The current rules allow reimbursement…An original bill and a reconsideration were submitted, the current rules allow reimbursement."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this dispute.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 16, 2012	99456-WP-W5	$100.00	$100.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for the reimbursement of workers' compensation specific services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 16, 2012
   - W1 – Reimbursement has been calculated according to the state fee schedule guidelines.

   Explanation of benefits dated April 16, 2012
   - 18 – The submitted charges are duplicates of previously submitted bills in the amount of $

Issues

1. What are the billing guidelines for an Impairment Rating (IR) and Maximum Medical Improvement (MMI) exam per 28 Texas Administrative Code §134.204?

2. Does the requestor's documentation support services as billed?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (j)(1)(A) & (B) state, "(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier 'W5" is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier 'W5" is the first modifier to be applied when performed by a designated doctor."

   28 Texas Administrative Code §134.204(j)(3)(C) states, "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

   28 Texas Administrative Code §134.204(j)(4)(C)&(i-iii) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (1) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion is performed: (a) $300 for the first musculoskeletal body area; (b) $150 for each additional musculoskeletal body area. (iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.
2. The requestor billed disputed services with CPT Code 99456-WP-W5 for a Division approved exam to determine maximum medical improvement (MMI) and impairment rating (IR). A review of the medical records support that the requestor completed a MMI/IR exam with range of motion of the upper extremities (elbow and forearm) and cervical.
3. Per 28 Texas Administrative Code §134.204 (j) reimbursement is recommended as follows:

   CPT Code 99456-WP-W5: Examining doctor other than treating doctor, Reimbursement shall be $350. The MAR for a full physical evaluation with range of motion of the first musculoskeletal body area (cervical) is $300. The MAR for each additional musculoskeletal body area (upper extremities, elbow and forearm) is $150. Review of the explanations of benefits indicates that the respondent made a payment in the amount of $700. Requestor is seeking additional reimbursement of $100. Therefore in accordance with28 Texas Administrative Code §134.204 (j), additional reimbursement is recommended in the amount of $100.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $100.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $100 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 1, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box

17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.